Huey P Long Medical Center
LSU HEALTH SHREVEPORT

Huey P. Long
352 Hospital Blvd.
Pineville, LA 71360

VRC
Vital Records Control

Phone Number: (251) 300-8053
Fax: 251-220-0111 Email: clinics@Vital-Chart.com

551 Western Dr.
Mobile, AL 36607

Patient Identification

Patient Name: _____ SS#: _____

DOB_____ Address: _____ Phone #: _____

Authority to Release Protected Health Information

I hereby authorize VitalRecords/LSUHSC Huey P. Long to release the information identified in this authorization form for the medical records of _____ and provide such information to:
(Patient's Name)

Facility Receiving PHI _____

Attn: _____

Address: _____ Phone: _____ Fax: _____

Please check the type on information to be released:

☐ Complete Chart ☐ History & Physical ☐ Lab Tests ☐ ER Report ☐ X-Ray report ☐ Discharge Summary
☐ Progress Notes ☐ X-Ray films ☐ Itemized Bill ☐ Other (Specify)

Dates of Service Requested

From: _____ To: _____

Purpose of the Requested Disclosure of PHI

I am authorizing the release of my Protected Health Information for the following purposes:
☐ Legal /Attorney ☐ Insurance ☐ Disability ☐ Treatment ☐ Other (specify) _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or any other sensitive information, I agree to its release.
Check One: ☐ Yes ☐ No

I understand if my medical or billing records contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. **Check One:** ☐ Yes ☐ No

Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at anytime by submitting a written notice to **Release of Information at Vital Records Control.** Unless revoked, this authorization will expire one year from the date signed.

Re-Disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of information to a third-party (e.g. fitness-of-work test), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed. I hereby release and discharge Vital Records Control/LSUHSC Huey P. Long Medical Center of any liability and the undersigned will hold Vital Records Control/LSUHSC Huey P. Long Medical Center harmless for complying with this authorization.

Signature: _____ **Relationship:** _____ **Date:** _____

_____ ***Office Use Only*** _____

Signature verified by ☐ Proof of Identification ☐ Matching Signature ☐ Other: _____

Witness: _____ Date: _____